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No. 00-952

IN THE

Supreme Court of the United States

WISCONSIN DEPARTMENT OF HEALTH
AND FAMILY SERVICES,
Petitioner,

v.

IRENE BLUMER,
Respondent.

On Writ of Certiorari to the Wisconsin Court of Appeals District IV

BRIEF OF THE AMERICAN HEALTH CARE ASSOCIATION AS *AMICUS CURIAE* SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether spouses are entitled to an upward adjustment in the amount of resources they can protect as part of a "community spouse resource allowance" even though a state will make a sufficient amount of existing marital income available to the community spouse to ensure that the community spouse's monthly income allowance will meet the state-set minimum monthly maintenance needs allowance after, and while, Medicaid eligibility attaches.

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INTEREST OF *AMICUS CURIAE* AMERICAN HEALTH CARE ASSOCIATION

The American Health Care Association ("AHCA") respectfully submits this *amicus curiae* brief pursuant to Sup. Ct. R. 37 in support of reversal of the Wisconsin Court of Appeals' June 8, 2000 decision in *Blumer* v. *Wisconsin Department of Health and Family Services*, 237 Wis. 2d 810, 615 N.W.2d 647 (2000).[1] AHCA is a private, voluntary, nonprofit federation of 51 affiliated state associations representing more than 11,000 non-profit and proprietary long term care (nursing home) providers. AHCA representation encompasses about two-thirds of the nation's 16,000 nursing homes, most of which provide nursing facility services to Medicaid-eligible beneficiaries under state Medicaid programs.

As a result of the landmark nursing home reforms of the Omnibus Budget Reconciliation Act of 1987 ("OBRA 1987"), P.L. 100-203, nursing homes that enter into provider agreements with the Secretary of the Department of Health and Human Services ("HHS") to participate in the Medicare and/or Medicaid programs must meet numerous federal standards governing the provision of long term care services. The ultimate goal ascribed to these standards is to ensure that nursing homes furnish the "highest practicable" level of care to their residents. *See* 42 U.S.C. §§ 1395i-3, 1396r; 42 C.F.R. Part 483. Meeting the federal standards requires clinical expertise, teamwork and dedication from a variety of health care professionals and nursing home staff. It also requires substantial financial outlays. AHCA, the largest national trade association representing long term care providers, is committed to assisting its members in achieving OBRA

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[1] Both parties consented to the filing of this brief; copies of letters reflecting the parties' written consents are attached to the Certificate of Service. No part of this brief was authored by counsel for either party and reimbursement for the costs associated with preparation and submission of this brief came exclusively from AHCA.

1987's goals through, among other things, advocacy of financial policies and statutory and regulatory regimes designed to ensure that adequate funding is available to cover the costs that long term care facilities incur in meeting the needs of the residents they serve.

Because the commercial insurance market for long term care coverage is fairly undeveloped, long term care facilities must recoup their costs primarily through the Medicare and Medicaid programs or private-pay arrangements with individuals. But Medicare coverage is temporary and Medicaid payments are significantly restricted. Thus, nursing homes must ensure that their operating costs are met by balancing any public program reimbursement they receive against revenue they can obtain from private-pay sources.

A "resource first" approach dries up the crucial private-payor source of revenue for long term care facilities while increasing the financial burdens placed on state Medicaid programs by accelerating a married applicant's eligibility for Medicaid. Essentially, it deems resources that would have been available to help finance health care off-limits even though sufficient marital income exists to ensure that the spouse not on public assistance is not impoverished.

SUMMARY OF THE ARGUMENT

The issue in this and similar cases is generally framed as whether 42 U.S.C. § 1396r-5(e)(2)(C) mandates what has commonly been termed a "resource first" approach to rectify a deficient minimum monthly maintenance needs allowance ("MMMNA") under the Medicaid statute's so called "spousal impoverishment" provisions. But essentially, the issue is one of ripeness, specifically: whether spouses have any "fair hearing" right to increase the community spouse resource allowance ("CSRA") under 42 U.S.C. § 1396r-5(e)(2)(C) where they cannot demonstrate that a community spouse's post-eligibility monthly income will fail to meet the state-set MMMNA level. The Wisconsin Court of Appeals determine-

ed that the spouses involved in the appeal before it were permitted a resource adjustment only after the court first deemed "unavailable" marital income that would in fact be available when needed to supplement a community spouse's income allowance.

According to the Wisconsin Court of Appeals, 42 U.S.C. § 1396r-5(e)(2)(C) "very specifically directs the increase of the [CSRA] to an amount sufficient to generate additional income to meet the [community spouse's MMMNA]." *Blumer*, 615 N.W.2d at 653. And even though the appeal provision contemplates that a community spouse's monthly income will first fall below the state's MMMNA, the Wisconsin Court decided that "[b]ecause § 1396r-5(d) (relating to the transfer of income) is limited to post-eligibility determination transfers, while increasing the CSRA pursuant to § 1396r-5(e)(2)(C) is not so limited, then increasing the CSRA via resources is the only method by which *a community spouse can be afforded more income for the MMMNA at the time MA [Medicaid] eligibility is being determined for the institutional spouse*." *Id.* (emphasis added). The court erases marital income that actually exists, and will be available to the community spouse after Medicaid eligibility attaches, from calculations that are intended to determine what the community spouse's monthly income will be after eligibility attaches by deeming the institutional spouse's income off-limits before eligibility attaches.

The court's analysis is fundamentally flawed. The court assumes that a community spouse somewhere gains a right to be afforded a minimum income stream from marital assets before Medicaid eligibility attaches. The court fails to recognize that a minimum income level is protected only after eligibility attaches. This truism should have been apparent to the court from placement of the income allowance provisions within a section that operates post-eligibility and the discussion in the legislative history. But by interpreting the spousal impoverishment provisions from back to front,

the court manages only to turn the intent of the Medicaid Act upside down. From the fact that income transfers from an institutional spouse to a community spouse are only discussed in a post-eligibility provision, it gleans a non-existent pre-eligibility rule restricting how income may then be used. What the court fails to grasp is that Medicaid has no anti-deeming provisions that apply to marital income before eligibility attaches. In fact, aside from requiring that pre-eligibility asset transfers be for fair market value, Medicaid places no pre-eligibility restrictions on how income may be used. Only after eligibility attaches does Medicaid confront how income attributed to the eligible individual may be used.

Post-eligibility, Congress explicitly contemplated only that income attributed to the community spouse would be off-limits to Medicaid. But Congress explicitly allowed states, in cases where the community spouse's protected income was not sufficient to meet the allowable monthly minimum, to make income that the couple otherwise would have been required to spend on the institutional spouse's Medicaid program costs available instead for use by the community spouse. Where, after eligibility attaches, a state will make marital income available to a community spouse before it applies any remainder to the costs of health care, the statute does not contemplate that available marital income can be ignored so that the predicate for a CRSA adjustment—demonstration that a post eligibility income stream will be inadequate—can be found.

The Wisconsin Court of Appeals misconstrues the statute, and then, upon deciding that its construction is clear, ignores conflicting views in the legislative history and from the agency authorized to administer the program. By inferring a pre-eligibility right to receipt of a particular income level, the court eliminated a right that Congress left to the states to decide how a community spouse income allowance might be funded when required.

ARGUMENT

A. Background

1. Decisions Below

In 1996, two years after respondent Irene Blumer was admitted to a nursing home, her husband, who continued to live in the community, applied for Medicaid on her behalf. Income attributable to Irene Blumer did not disqualify her from Medicaid eligibility after her costs of medical care were considered. Consequently, the only eligibility issue was whether overall marital resources exceeded, by more than $2,000,[2] the value of Mr. Blumer's "CSRA."[3]

Irene Blumer's application showed that the couple's marital assets totaled $145,644 when Irene Blumer became institutionalized in 1994. The reviewing agency determined that Wisconsin's spousal impoverishment rules permitted the couple to shield a CSRA of $72,822 for Mr. Blumer (in this case half the marital total), plus $2,000 that can be protected for his institutionalized spouse. As of the date of respondent's Medicaid application, however, the couple retained marital assets totaling $89,335, or $14,513 more than the eligibility threshold permitted. Her application was rejected. *Blumer*, 615 N.W.2d at 648.

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[2] Federal and Wisconsin laws disqualify institutional spouses with more than $2000 in liquid assets. *See* 20 C.F.R. § 416.1205; Wisc. Stats. § 49.47(4)(b)(3g)(e).

[3] If they did, Section 1902(a)(17) of the Social Security Act (42 U.S.C. § 1396a(a)(17)) and related provisions under state law would continue to disqualify the spouse from Medicaid until the excess marital resources were exhausted. Except to require that assets be exhausted for fair market value, Congress does not tell couples how to spend assets before eligibility attaches. As a practical matter, however, while a spouse continues to reside in a nursing home, costs of nursing care will consume additional income and resources until overall assets fall to a level where Medicaid eligibility attaches.

Respondent pursued an appeal through the "fair hearing" provisions of Section 1924(e)(2)(C) of the Social Security Act (42 U.S.C. § 1396r-5(e)(2)(C)). She contended that she and/or her community spouse should not be required to exhaust $14,513 in additional assets before she qualified for Medicaid. According to Irene Blumer, those marital assets attributed to her were also subject to shelter within an expanded CSRA to which Mr. Blumer was entitled because the income attributed to him fell below Wisconsin's MMMNA. *Id.* at 648-649.

At the hearing, respondent demonstrated that the monthly income attributable to Mr. Blumer was $1,702.45 (including his social security, an annuity, and $377.85 derived from his $74,822 resource allowance). Because that amount fell $25 below the MMMNA then in effect, she asserted that Mr. Blumer should be able to raise his CSRA. Before adjusting the amount of protectible assets, however, the examiner applied the income-first rule in Wis. Stat. § 49.455(8)(d). In effect, the examiner determined that sufficient marital income existed, and would continue to exist, to make up the $25 shortfall, because, while Irene Blumer remained on Medicaid, Wisconsin's Medicaide Program made some of her $1162.71 in monthly income available to her husband. *Id.*

The Wisconsin Court of Appeals overturned the manner by which Wisconsin guaranteed Mr. Blumer's income allowance. It concluded that Wisconsin's income-first statute violated federal law. *Id.* at 655. The Court of Appeals based this determination on its view that the CSRA adjustment occurs during a pre-eligibility determination process, while the provision explicitly permitting the use of an institutional spouse's income to supplement any shortfall in community spouse's income allowance is set forth in a post-eligibility provision. *Id.* at 653.

The Wisconsin Supreme Court denied review.

2. Medicaid Eligibility and Income Protection Under the Spousal Impoverishment Provisions

The Medicaid program is fundamentally a needs-based welfare program for the poor. As this Court noted in *Schweiker v. Hogan*, 457 U.S. 569, 590 (1982):

> In establishing public assistance programs, Congress often has determined that the Federal Government cannot finance a program that provides meaningful benefits in equal measure to everyone. Both federal and state funds for such assistance are limited. In structuring the Medicaid program, Congress chose to direct those limited funds to persons who were most impoverished and who—because of their physical characteristics—were often least able to overcome the effects of poverty. . . . It is rational to distribute public assistance benefits on the basis of the income and resources available to potential recipients.

An individual's eligibility for Medicaid requires testing both income and resources. Under the income eligibility provisions of Section 1902(f) of the Social Security Act, 42 U.S.C. § 1396a(f), a state participating in Medicaid may not exclude an individual on the basis of his or her income if income does not exceed thresholds calculated after deducting the expenses that individual incurs for medical care. But even though medical expenses may ensure that excess income does not exist to disqualify an individual, Section 1902(a)(17) of the Social Security Act permits states to exclude individuals with assets in excess of eligibility thresholds, until such excess assets are exhausted. *See* 42 U.S.C. § 1396a(a)(17).

The spousal impoverishment provisions at issue here did not change the eligibility thresholds applicable to an institutional spouse. Instead, the provisions revised how marital income and assets would be attributed to institutional spouses for eligibility purposes and protected after eligibility attached.

Prior to the enactment of 42 U.S.C. § 1396r-5 in 1988, rules governing Medicaid eligibility of an institutionalized spouse did not allow for much financial protection of the needs of the spouse who remained in the community. This was the case because Medicaid eligibility rules assumed that most or all of a couple's marital income and resources could and should be dedicated to the cost of caring for the institutionalized spouse. Medicaid regulations initially permitted the protection of a very limited amount of income for a community spouse's needs. *See, e.g.*, 42 C.F.R. § 435.700 *et seq.* (1980). At the same time, most of the couple's joint assets, and any assets owned solely by the institutional spouse, were deemed available for the cost of that spouse's care. In essence, the eligibility rules governing married couples forced such couples to liquidate nearly all of their joint assets in order to qualify one of the spouses for Medicaid. As a result, the community spouse frequently was left with no resources. Moreover, even after assets were expended and eligibility had attached, most of the couple's marital income had to be used to offset the cost to Medicaid of the nursing home care it now subsidized. *See* H.R. Rep. No. 105(II) at 65-67, *reprinted in* 1988 U.S.C.C.A.N. at 888-890.

At the same time, however, couples often avoided paying for institutional care of the institutionalized spouse by simply transferring their joint assets to the community spouse where they would be deemed, under principles then in effect, unavailable to the institutional spouse. *See id.* at 73, 1988 U.S.C.C.A.N. at 896.

Through enactment of the spousal impoverishment provisions (and transfer restrictions), Congress sought to address *both* of these problems. As indicated in the House Energy and Commerce Committee Report, "The purpose of the Committee bill is to end this pauperization by assuring that the community spouse has a sufficient—*but not excessive*—amount of income and resources available to her

while her spouse is in a nursing home at Medicaid expense." *Id.* at 65, 1988 U.S.C.C.A.N. at 888 (emphasis added).[4]

The protection afforded the community spouse by Congress was clearly limited. First, as is plain from the language of the statute, the community spouse generally is only entitled to "shelter" a *portion* of marital income (*i.e.*, income attributed to the community spouse or made available to that spouse to meet the MMMNA) and marital resources (*i.e.*, the CSRA) from Medicaid "spend down" and exhaustion requirements. 42 U.S.C. § 1396r-5(c)(2). Thus, while providing the community spouse with a minimum level of resources, this limitation also ensures that "no one escapes contributing a fair share to nursing home care costs." 133 Cong. Rec. H6453 (daily ed. July 22, 1987) (statement of Rep. Tauke). Second, the committee report language quoted in the previous paragraph makes it equally clear that the income protection afforded the community spouse through the MMMNA applies *only during the period of Medicaid eligibility*. Indeed, once an institutionalized spouse no longer requires institutional care (*e.g.*, upon discharge or death), his or her spouse ceases to qualify as a "community spouse" under the statutory definition. *See* 42 U.S.C. § 1396r-5(h)(2).[5]

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[4] In addition to the spousal impoverishment provisions requiring application of marital resources toward the cost of institutional care, Congress simultaneously enacted provisions that limit couples' ability to transfer assets to the community spouse or their children to avoid applying those assets to the cost of health care. *See* 42 U.S.C. § 1396p. In enacting these separate restrictions as part of the same statutory section that included the spousal impoverishment provisions, Congress noted that "an entitlement program for the poor should not facilitate the transfer of accumulated wealth from nursing home patients to their non-dependent children." H.R. Rep. No. 105 at 73, *reprinted in* 1988 U.S.C.C.A.N. at 896. *See also infra*, Section C.

[5] For this reason, the Court of Appeals' apparent concern that an income first approach could leave the community spouse with income less

Under the spousal impoverishment provisions of the Medicaid statute, when a married individual enters a nursing facility that participates in Medicaid, the facility resident and his spouse are entitled to a notice of the resident's right to apply for Medicaid and of the couple's right to an assessment of their resources. 42 U.S.C. § 1396r-5(c)(1)(B). This assessment ultimately is used to determine whether, and, if not, what must occur before, the institutionalized spouse is eligible for Medicaid. In conjunction with the eligibility assessment, the provisions address the existence, if any, of a share of marital income and resources that historically might have disqualified the institutional spouse from Medicaid but which will no longer be deemed "available" to the institutional spouse to cover the costs of medical care. 42 U.S.C. § 1396r-5.

With respect to the eligibility assessment, the provisions establish new rules regarding the attribution and availability of marital income and resources between the institutionalized spouse and the community spouse. With respect to income attribution, the statute basically incorporates a "name on the check" principle which deems income payable to either spouse "available" only to that spouse. If income is payable to both spouses, it is generally divided evenly between the two spouses. 42 U.S.C. § 1396r-5(b)(2).

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than the MMMNA upon the death of the institutionalized spouse (insofar as the community spouse's revised Social Security payments may be less than the couple's aggregate Social Security payments), *Blumer v. Wisconsin Department of Health and Family Services*, 237 Wisc. 2d 810, 615 N.W. 2d 647, 654 (2000), is misplaced. Upon the death of the institutionalized spouse, the community spouse is simply not entitled to continue to receive an MMMNA. Moreover, it is equally possible that the community spouse's "direct" income may exceed the MMMNA, or that income from other sources (like insurance) will come into play. Further, in cases in which it does not, community spouses would still have the "principal" amount of the "standard" CSRA (as well as their home, personal effects, and an automobile) available to meet their needs.

In contrast, with respect to resource attribution, the name on the title is irrelevant. Instead, the statute initially evaluates the value of all marital resources that were available to the couple when the institutionalized spouse's need for institutional care began. *Id.* § 1396r-5(c)(1)(A). In computing the marital resources potentially available to the institutionalized spouse, however, the value of the couple's home, personal effects, and automobile, among other things, is disregarded. *Id.* § 1396r-5(c)(5). *See id.* § 1382b.

Within the statute's income and resource attribution sections are rules for determining how much of the marital income and resources may be considered "available" to the institutionalized spouse for Medicaid eligibility purposes—or, on the flip side, unprotectible. With respect to income, the statute prevents disqualification on the basis of any income attributed to the community spouse. Specifically, 42 U.S.C. § 1396r-5(b)(1) provides that "no income of the community spouse shall be deemed available to the institutionalized spouse." Essentially, all marital income is deemed available to the institutional spouse, *except* what is deemed available only to the community spouse.

Similarly, all of the countable marital resources (resources not specifically excluded from attribution under subsection (c)(5)) are considered available to the institutionalized spouse, *except* for an additional CSRA. *Id.* § 1396r-5(c)(2). The CSRA is the greatest of: (i) $12,000 (adjusted for inflation) or, if a greater amount is specified under a state plan, that amount (but not to exceed $60,000 before inflation adjustment); (ii) the lesser of the "spousal share" [6] or $60,000 (adjusted for inflation); (iii) an amount established pursuant to a fair hearing; or (iv) an amount specified by a court order

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[6] The "spousal share" is fifty percent of the total "countable" marital resources. *Id.* § 1396r-5(c)(1)(B).

for support. *Id.* § 1396r-5(f)(2).[7] After the institutionalized spouse is determined to be eligible for Medicaid, he or she may transfer to or for the sole benefit of the community spouse an amount necessary to ensure that the community spouse retains his or her CSRA without violating 42 U.S.C. § 1396p(c)(1)(A)'s prohibition against asset transfers for less than fair market value. *Id.* § 1396r-5(f)(1).

In addition to crafting new marital asset attribution rules for spousal eligibility determinations, the statute is also designed to provide a limited amount of financial protection for the community spouse. As noted above, the statute already allows the community spouse to retain the couple's home, automobile and personal effects; newly protects additional marital resources within a CSRA; and also shields income attributed to the community spouse from being deemed available to the institutionalized spouse to pay for his or her health care costs. These assets and income already protected for the community spouse may be sufficient for that spouse to live on while his or her spouse remains on Medicaid. But to ensure that the protected combination of income and resources suffice, and that if they do not, additional marital income and resources are also made available for the community spouse's benefit, Congress required each state to establish a MMMNA. The MMMNA for the community spouse can vary from state to state but must equal at least 150% of the federal poverty level while not exceeding $1,500 per month (before adjustment for inflation). 42 U.S.C. § 1396r-5(d)(3). The MMMNA operates to guarantee a minimum monthly income to the community spouse (assuming that the couple has sufficient income and assets to generate the MMMNA) while the institutional spouse remains institutionalized on Medicaid.

[7] During the period relevant to this appeal, the maximum "standard" CSRA in Wisconsin was $76,740.

In the event that income directly attributable to the community spouse is less than the MMMNA, the statute provides that "there shall be deducted" from the institutionalized spouse's monthly income, a "community spouse monthly income allowance . . . , but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse." *Id.* § 1396r-5(d)(1)(B). In other words, if the community spouse's monthly income falls below the MMMNA, a state Medicaid program may apply income available to the institutionalized spouse, which under the old rules the state was permitted to apply entirely to offset Medicaid's costs, instead to offset the community spouse's income shortfall.

In some cases, however, the combination of income deemed available only to the community spouse and income deemed available to the institutionalized spouse that is made available to the community spouse may still be insufficient to meet the MMMNA. In those circumstances, the statute provides in a separate subsection for fair hearings at which either spouse may request an increase in the "standard" CSRA by an amount necessary to generate sufficient income to make up any shortfall in the monthly income allowance. The fair hearing provision, which is the basis for the claim here, states as follows:

> If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

42 U.S.C. § 1396r-5(e)(2)(C).

B. The Court of Appeals' Pre-Eligibility Exclusion of Marital Income as One Means for a State to Ensure that the MMMNA is Met is Wrong Because the MMMNA is a Post-Eligibility Income Protection Provision that Congress Expressly Indicated a State Could Fund Using Income that was Made Available After Medicaid Eligibility Attached.

As described above, the Medicaid statute clearly authorizes both income transfers and resource transfers to enable a community spouse to realize his or her MMMNA. *See* 42 U.S.C. §§ 1396r-5(d), (e)(2)(C). Significantly, whereas the statute broadly provides that no income of the community spouse may be attributed to the institutionalized spouse in 42 U.S.C. § 1396r-5(b)(1), there is no converse limitation precluding attribution of the institutionalized spouse's income to the community spouse.

The issue in this case relates solely to the *order* in which various potential sources of marital income may be applied to make up the community spouse's MMMNA. Essentially, there are four potential sources of marital income from which the community spouse may draw a post-eligibility income sufficient to meet the MMMNA: (i) income directly attributable only to the community spouse; (ii) income generated from the community spouse's CSRA; (iii) income attributable to the institutionalized spouse and made available to the community spouse (during the period when the community spouse has a right to protect a monthly income allowance); and (iv) income generated from resources attributable to the institutionalized spouse that are transferred to the community spouse as part of an adjustment to the CSRA pursuant to a fair hearing. The parties agree that income from categories (i) and (ii) cannot be disregarded and must be applied first when calculating the sufficiency of a community spouse's income. Respondent and the Wisconsin Court of Appeals contend that, if there still is a shortfall after that application,

the statute mandates that income from category (iv) must be applied next under a "resource first" approach, before income from category (iii) may be applied (if at all).

The Wisconsin Court of Appeals held that income from resources (category (iv)) must be made available first because Congress did not intend income attributed to the institutionalized spouse to be factored into the MMMNA calculations before eligibility attaches. *Blumer*, 615 N.W.2d at 651-652. According to the Wisconsin court, income that may be available post-eligibility is irrelevant to calculations that are necessarily being performed before eligibility attaches because the statute only discusses supplementing a community spouse's income allowance with income attributed to the institutional spouse in a, provision that applies *after* eligibility for Medicaid attaches. *Id.* at 653.

In actuality, the entire statute focuses on the post-eligibility period. Resource transfers also occur only *after* eligibility attaches. *See* 42 U.S.C. § 1396r-5(f)(1). There is no mystery behind Congress' discussion of both income and resource transfers from an institutional spouse's marital assets only after eligibility attaches. Medicaid provides no guarantee that sufficient marital income will be made available to a community spouse before eligibility occurs. The community spouse monthly income allowance is exclusively a post-eligibility protection.

Medicaid's concern with the post-eligibility period here is entirely consistent with how Medicaid otherwise operates. Medicaid places only one restriction on how any individual who may become eligible for Medicaid (or the spouse), but is not yet eligible, may choose to spend assets. If assets (defined to include "income" and "resources" under 42 U.S.C. 1396p(e)) are transferred for less than fair market value within certain pre-eligibility windows, eligibility may be postponed. *See* 42 U.S.C. § 1396p(c)(1)(A). Income (and resource transfers) are discussed post-eligibility—not because

Congress somehow intended to elevate the significance of resources—but because, except as provided in Section 1396p, until Medicaid starts paying, Medicaid laws do not regulate how spouses may share marital income and resources.

Even though the Medicaid program does not tell married couples where they may spend any income before either becomes Medicaid-eligible, the Wisconsin Court of Appeals assumes into the Medicaid program a community spousal right to collect a MMMNA, before eligibility attaches, from assets of an institutionalized spouse. Based on a premise that there is payment right before an eligibility determination, and based on Congress' discussion of income transfers only post-eligibility (where they belong), the court decides that "increasing the CSRA via resources is the only method by which a community spouse can be afforded *more income at the time MA eligibility is being determined* for the institutional spouse." *Blumer*, 615 N.W.2d at 653 (emphasis added).

In truth, there exists no right under the Medicaid Act to "more income at the time MA eligibility is being determined." The spousal impoverishment provisions nowhere contemplate any pre-eligibility income allowance payment. Instead, establishment and payment of a "community spouse income allowance" is detailed within a subsection that discusses what will occur "[a]fter an institutionalized spouse is determined or redetermined to be eligible for Medical assistance," and which—even begins with the words: "ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONAL SPOUSE." 42 U.S.C. § 1396r-5(d)(1) & (2). Next, within the same subsection and immediately following the provisions establishing the potential right to protect an income allowance, Congress defines the MMMNA. It then becomes the basis for determining whether payment of a allowance from any marital assets will occur. *See* 42 U.S.C. § 1396r-5(d)(3).

In sum, the spousal impoverishment provisions protect a MMMNA only after eligibility attaches and, then, only while eligibility continues. Consequently, there is no legal basis for concluding that institutional spouse income that will be in existence after eligibility attaches, and that will be made available to supplement the allowance payment at the time that the payment "becomes due," may not factor into eligibility calculations. Income that will be available when a state is obligated to protect an income allowance need not be ignored.[8]

Some courts have suggested that even though the community spouse is entitled to protect an income level up to the MMMNA *after* the institutionalized spouse becomes eligible for Medicaid, the statutory authorization for an adjustment to the CSRA under subsection (e)(2)(C) would be rendered

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[8] The Wisconsin Court of Appeals also found significant the fact that "the community spouse's income," as used in subsection (e)(2)(C), is never defined to mean "the couple's income or the community spouse's income plus the institutionalized spouse's income." *Blumer*, 615 N.W.2d at 653. That hardly gives the court license to transform the phrase "the community spouse's income" into the phrase "the income the community spouse receives from the CSRA to a level that meets the MMMNA." The spousal impoverishment provisions provide that, "[except as [Section 1924 of the Act] specifically provides [it] does not apply to . . . the determination of what constitutes income or resources[.]" 42 U.S.C. § 1396r-5(a)(3). The income attribution principles from which the court gleans a basis for subtracting any pre-eligibility income attributed to the institutional spouse also do not operate to control how income is marital income is distributed pre-eligibility. Rather, the income attribution principles explicitly involve only "determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in [the post-eligibility income allowance provisions of] subsection (d)[.]" 42. U.S.C. § 1396r-5(b)(2). At a minimum, because the Secretary administers the Act and is authorized to prescribe standards in the area of what constitutes income, 42 U.S.C. § 1396a(a)(17), the court should have looked at agency guidance before writing its own definition. *See, e.g., Cleary* v. *Waldman*, 167 F.3d 801, 807 (3rd Cir. 1999).

meaningless in the post-eligibility context under an income first approach because the couple's resources already would have been spent by the institutionalized spouse. That suggestion ignores the fact that nothing in the statute precludes an assessment and allocation of income at the pre-eligibility stage (as was done in this case) to ensure that, post-eligibility, the MMMNA can be met. Indeed, as the district court found in *Cleary*, the income and resource attribution may occur together at a pre-eligibility assessment (and, if necessary, at a hearing) to *preserve* a community spouse's ability to realize the full MMMNA by ensuring that an appropriate amount of resources are available prior to spend down if the community spouse's income and any transferred income from the institutionalized spouse will be insufficient to make up the MMMNA. *Cleary v. Waldman*, 959 F. Supp. 222, 232 (D.N.J. 1997), *aff'd* 167 F.3d 801 (3d Cir.), *cert. denied*, 528 U.S. 870 (1999).

In context and sequentially applied, the spousal impoverishment eligibility and income protection rules make sense. Their application to the facts here demonstrates that the eligibility determinations Wisconsin made were accurate and appropriate. Essentially, Wisconsin provided a pre-eligibility right to appeal in order to ensure protection of a post-eligibility allowance. But recognizing that the allowance attaches post-eligibility, and that sufficient income would be made available at that time to fund the community spouse's income allowance, Wisconsin appropriately denied the request to adjust the CSRA. Federal law countenances exactly what Wisconsin allowed.[9]

[9] Indeed, the basic income protection afforded the community spouse through the MMMNA and through payment of a "community spouse monthly income allowance" is established in subsection (d) of 42 U.S.C. § 1396r-5. The authority for income transfers to enable the community spouse to achieve the MMMNA is contained in that same section. The

C. Wisconsin's Approach To Implementing 42 U.S.C. § 1396r-5 Is Consistent With the Medicaid Program's "Core Value" Of Individual Responsibility For Health Care Costs and with Congressional Enactments that Control Asset Transfers Intended to Expedite Program Eligibility

Mandating a resource first approach to the spousal impoverishment provisions would frustrate a Congressional goal of allowing each state to control Medicaid eligibility, in part, by establishing its own "standard" CSRA. An income deficiency could be temporarily "manufactured" by subtracting from available marital assets income that would have been sufficient to meet the MMMNA once it became payable. Thereafter, couples routinely would be permitted to seek a transfer of marital resources in an amount that exceeded the state's standard statutory CSRA ceiling in order to generate sufficient income (coupled only with the community spouse's "attributed" income) to guarantee the community spouse a MMMNA for life. Nothing in the statute or its legislative history suggest that Congress intended to impose on states the obligation to create lifetime "trusts" that would assure streams of income to community spouses. Instead, as noted above, the income protections of the spousal impoverishment provisions were intended to apply only when Medicaid was paying for the institutional care.

Notably, in enacting the spousal impoverishment provisions, Congress rejected a proposal to require that the MMMNA be fully funded through a resource transfer in a manner similar to the resource first approach embraced by the Wisconsin court. The initial House Bill in 1988 did not provide for an adjustment to resources to meet the MMMNA. The Senate Bill (S.1127), by contrast, allowed for a broad

proximate placement tends to suggest that Congress viewed income transfers as the primary means for resolving MMMNA shortfalls.

exclusion from countable resources of amounts necessary to meet the MMMNA. But the Conference Committee rejected the Senate's broad approach to protecting additional resources. *See Chambers v. Ohio Dept. of Human Services*, 145 F.3d 793, 803-804 (6th Cir. 1998); *Cleary*, 167 F.3d at 811.

Moreover, Congress continually has emphasized, outside of the specific context of the spousal impoverishment provisions, that individual responsibility for health care expenses prior to Medicaid eligibility remains a paramount public policy if the Medicaid program is to be preserved as a poverty-based program. The primary method of assuring that the program is available only to the most needy has been through restrictions on transfers of assets in order to secure Medicaid eligibility. *See* 42 U.S.C. § 1396p.

In 1980, Congress enacted a rule permitting states to deem a person ineligible for Medicaid for up to 24 months if he or she transferred assets for less than fair market value to become Medicaid eligible. *See* Omnibus Reconciliation Act of 1980, P.L. 96-611, § 5, 94 Stat. 3567. Congress expanded the assets subject to these restrictions as part of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 94-248. As noted earlier, Congress tightened these rules even further in conjunction with the enactment of the spousal impoverishment provisions by mandating the transfer of assets rule and expanding the ineligibility period. *See supra* note 4. Congress again closed loopholes in the asset transfer prohibitions in 1989 and 1993. *See* Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, § 6411(e); Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, § 13611. Finally, as part of the recent Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), P.L. 104-191, Congress enacted federal *criminal* penalties for improper transfers of assets for the purpose of qualifying for Medicaid. HIPAA, § 217. *See* 42 U.S.C. § 1320a-7(b)(a)(6).

Finally, recent federal legislation provides incentives for individuals to avoid the potential for impoverishment while simultaneously protecting assets through the purchase of a long term care insurance policy. Specifically, as part of HIPAA, Congress sought to expand the use of long term care insurance by providing tax incentives for individuals to purchase appropriate coverage, as well as minimum standards for such policies. *See* HIPAA, P.L. No. 104-191, § 321. HIPAA excludes amounts received under qualifying policies from gross income, and individuals may deduct unreimbursed expenses and premium costs as medical expenses. In enacting these provisions, Congress once again sought to provide incentives for individuals to take financial responsibility for their long term care needs. *See* H.R. Rep. No. 496 at 115, *reprinted in* 1996 U.S.C.C.A.N. at 1916.

D. An Income First Approach Is Consistent With A Permissible Federal Interpretation Of the Spousal Impoverishment Provisions By the Agency Empowered to Administer the Medicaid Program

The language, structure, legislative history and public policies underlying the Medicaid program confirm that an income first approach is an appropriate way to implement the spousal impoverishment provisions. In addition, the Centers for Medicare and Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"), the federal agency charged with interpreting the Medicaid statute, permits states to implement the spousal impoverishment provisions through an income first approach. Even if the Court found that the features of the statute and legislative history did not establish conclusively that Congress did not impose a resource first approach, in light of longstanding administrative law principles requiring deference to permissible agency interpretations, Wisconsin's income first approach should be upheld. Wisconsin's adoption of an income first approach is consistent with a

permissible interpretation of the statute by the federal agency charged with implementing the Medicaid statute.

In *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), this Court set forth the following test for construing statutes in light of agency interpretations:

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a *permissible* construction of the statute.

467 U.S. at 842-43 (emphasis added). A permissible construction need not be the only possible construction of the statute, or even the construction that a court would adopt if examining the issue as a matter of first impression in the absence of an administrative interpretation. *Id.* n.11. Recently, in *United States v. Mead Corp.*, __ U.S. __, 121 S. Ct. 2164, 2177 (2001), this Court reaffirmed that even where *Chevron* deference does not apply, a reasonable statutory interpretation by the agency charged with administering the statute is entitled to some deference under *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944).

Formal regulations implementing the spousal impoverishment provisions have not yet been adopted. However, HCFA issued interpretive manuals that provide guidance with

respect to the operation of the Medicaid program. In 1989, HCFA issued an interpretation of the spousal impoverishment provisions as part of its State Medicaid Manual ("SMM"), HCFA Pub. 45, which indicated that states were required to adopt an income first approach. The Manual provides:

> When either member of couples establish that income generated from resources deducted as community spouses' spousal allowances are inadequate to raise community spouses' income to the minimum amount to be deducted as a maintenance allowance in the post-eligibility determination, substitute the resource amount calculated in subsection B, step 2. for amounts State hearings officers determine to be adequate to provide the minimum monthly income allowance. *There are no substitutions when institutionalized spouses do not make available monthly income to community spouses.*

SMM § 3262.3 (emphasis added). *See also* SMM § 3703.4 ("For an individual with only a spouse at home, deduct from the individual's total income an amount for the maintenance needs of the spouse."). HCFA's Chicago Regional Office provided similar guidance in 1993, stating: "we are requiring that the institutionalized spouse must first make available the maximum amount of income he or she can as a community spouse monthly income allowance . . . before being allowed to raise the [CSRA] . . . ." Chicago Regional State Letter 51-93 (Dec. 1993). These interpretations make clear that HCFA has viewed the income first approach as a proper way to implement the spousal impoverishment provisions.

Although its manual provisions have not been rescinded, they also are not legislated rules. Consequently, HCFA retained discretion, which it has recently exercised, to take a more liberal view of what states may do with respect to the spousal impoverishment provisions. HCFA presently advises that the statute permits *either* an income first or a resource first approach that depends, essentially, on whether the state chooses to make the income of the institutional spouse

available first. *See* HCFA Memorandum from Medicaid Bureau Director Sally Richardson (March 1994); Chicago Regional State Letter 22-94 (July 1994); Letter from Donna E. Shalala to George V. Voinovich (March 1996). In either case, Wisconsin's income first approach has never been incon-sistent with HCFA guidance.

HCFA's interpretation of the spousal impoverishment provisions to allow states to implement an income first approach is a permissible interpretation of the statute in light of the fact that no explicit statutory provision or legislative history mandates a resource first approach. Thus, in the absence of compelling legislative materials supporting respondent's construction (and in light of the reasonableness of the state's approach), the state's income first approach should be sustained as a permissible interpretation of the statute under *Chevron*.

E. Congress Did Not Intend to Restructure Long Term Care Financing by Mandating a Resource First Approach

Long term care financing differs significantly from other health care financing by virtue of the fact that the private commercial insurance market for long term care has remained relatively undeveloped. In a 1995 report, the General Accounting Office ("GAO") estimated that 1993 nationwide spending on long term care was approximately $107.8 billion. Although various government programs were the primary sources of this funding, nearly $38.5 billion represented out-of-pocket payments by individuals and families. Private long term care insurance comprised only about $200 million of long term care spending. In other words, private pay revenues constituted over one-third of long term care spending and long term care insurance amounted to less than 0.2 percent of such spending. *See* General Accounting Office, *Long Term Care—Current Issues and Future Directions*, GAO/HEHS Report No. 95-109 (1995).

Various factors account for the limited market penetration of long term care insurance. The insurance industry approaches the long term care market with caution out of actuarial concerns that only those persons most likely to need long term care will purchase insurance and in light of its limited claims experience. *See id.* Additionally, the lack of uniform industry standards for such policies has raised consumer protection concerns. *See* General Accounting Office, *Long Term Care Insurance: Better Controls Needed to Protect Consumers*, GAO/HRD Report No. 92-66 (1992).

In the absence of a viable private insurance market, long term care facilities generally have been required to recoup the costs they incur caring for residents from other payment sources, including Medicare, Medicaid and private-pay arrangements with individual residents (or resident-responsible parties). But both public programs that cover care in a nursing home, Medicare and Medicaid, are subject to significant restrictions: Medicare is designed to be only a temporary source of long term care revenue,[10] while Medicaid imposes significant funding limitations.

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[10] Medicare, established by Title XVIII of the Social Security Act, is a federally funded health insurance program primarily for the aged, disabled, and certain persons with end stage renal disease. *See* 42 U.S.C. § 1395 *et seq*. The Medicare program covers "post hospital extended care services" furnished in a skilled nursing facility. 42 U.S.C. § 1395d(a)(2). But the skilled nursing facility benefit is not a principal form of long term care coverage due to several major limitations in the statute. First, Medicare defines "extended care services" as requiring skilled nursing or rehabilitation services on a daily basis that as a practical matter can only be provided on an inpatient basis. 42 U.S.C. § 1395x(h). *See* 42 C.F.R. §§ 409.31-.33. In other words, Medicare does not cover lower levels of "custodial" care in nursing homes. Second, Medicare generally requires an individual to have first had a three-day inpatient hospital stay, and be admitted to the skilled nursing facility within 30 days of discharge from the hospital. 42 U.S.C. § 1395x(i). *See* 42 C.F.R. § 409.30(a). Third, Medicare only covers up to 100 days per calendar year of skilled nursing care during any spell of illness (provided that the individual continues to

The Medicaid program, enacted by Title XIX of the Social Security Act, Pub. L. No. 89-97, 79 Stat. 343 (codified at 42 U.S.C. § 1396 *et seq.*), is a joint federal-state welfare program to provide medical assistance coverage to persons whose income and resources are insufficient to meet the costs of necessary medical services. *See* 42 C.F.R. §§ 435.600 *et seq.*; 436.600 *et seq.*; *Harris v. McRae*, 448 U.S. 297, 301 (1980). States have some flexibility to determine the precise types of benefits that will be covered under their respective Medicaid programs, but all states electing to participate in the Medicaid program must provide coverage for long term custodial care nursing facility services. *See* 42 U.S.C. §§ 1396a(a)(10)(A); 1396d(a)(4). In contrast to Medicare, Medicaid contains a broad long term care benefit covering nursing facility services and is presently the predominant source for long term care funding. Nevertheless, private payor revenue remains crucial to the financial viability of nursing homes because Medicaide does not necessarily cover its costs.

Consistent with the realization that Medicaid is intended as a public welfare program, it imposes not just significant income and resource limitations on individuals seeking coverage, but increasingly restrictive reimbursement limitations on providers of health care services. Prior to 1980, nursing facilities that participated in the Medicaid program received reimbursement on a "reasonable cost related" basis. 42 U.S.C. § 1396a(a)(13)(E) (1978). But starting in 1980, Congress enacted new payment provisions that eliminated cost-based reimbursement standards for nursing facilities under state Medicaid programs.[11] Congress now requires only that

need skilled services during such period). 42 U.S.C. § 1395d(a)(2). These limitations effectively mean that Medicare's skilled nursing facility benefit is principally designed as a short-term, post-hospital rehabilitative benefit, rather than as a long term care benefit.

[11] The first Medicaid payment provisions that revised Medicaid's cost-based reimbursement structure were collectively known as the Boren

Medicaid rates be determined through "a public process," without references to any substantive payment standards. 42 U.S.C. § 1396a(a)(13)(A)(2000).[12]

Even though Medicaid rates may not be adequate to cover the overall costs of each Medicaid resident's care, long term care facilities that elect to participate in state Medicaid programs are obligated by statute or regulation in many states to fill portions of their facilities with Medicaid-eligible residents.[13] At the same time, federal law prohibits the

Amendment. Under the Boren Amendment, Congress allowed states to pay for nursing facility services provided to Medicaid beneficiaries "through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . ." 42 U.S.C. § 1396a(a)(13)(A) (1995). The Boren Amendment was repealed in 1997, but cost based reimbursement never returned. Even while it remained in effect, post Boren decisions upheld Medicaid program rates that were not structured to cover all of the costs of each eligible individual's medical care. *See, e.g., New Jersey Ass'n of Health Care Facilities* v. *Gibbs*, 838 F. Supp. 881, 900, 903 (D.N.J. 1993) (upholding state's rates which left approximately 5-15% of total system costs [$70-140 million] unreimbursed and paid only 10-15% of Medicaid facilities their full allowable costs), *aff'd*, 14 F.3d 48 (3d Cir. 1994).

[12] The absence of payment standards has resulted in significant Medicaid reimbursement shortfalls. On August 30, 2001, BDO Seidman, LLP reported on shortfalls in Medicaid funding for long term care. Its report, commissioned by AHCA, studied 1999 Medicaid payment rates in thirty-six states and compared payment rates to nursing facilities' cost report data. BDO Seidman estimated that the annual Medicaid shortfall in these thirty-six states exceeded $2.5 billion, $3.3 billion when extrapolated over all fifty states. American Health Care Association, *A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care*, (August 30, 2001 BDO Seidman, LLP) Appendix 1 at 7.

[13] In New Jersey, for example, nursing homes must admit Medicaid patients up to certain thresholds. *See* N.J. Regs.10:5-12.2. Tennessee

discharge of a patient because of his or her status as a Medicaid patient. 42 U.S.C. § 1396r(c)(2)(A). In short, a nursing home's ability to manage its patient type and census in order to control spending remains limited too.

In light of the program constraints and statutory restrictions, government programs have permitted nursing homes to increase the rates they charge to private pay residents to cover the losses nursing homes may incur in caring for payment-limited residents. See *Cleary*, 959 F. Supp. 222 at 226. And, not surprisingly, charges generally are higher for private payors. For example, Wisconsin pays, on average, $3,336.90 per month to nursing homes that care for its Medicaid residents. *See* HCIA/Arthur Andersen, *The Guide to the Nursing Home Industry* (2001) at 143 (Appendix F) (Wisconsin average daily rate of $111.23). But when Wisconsin implements the asset transfer prohibitions of 42 U.S.C. § 1396p(c)(1)(A), it estimates that charges for private pay nursing facility residents in Wisconsin average $4,075 per month.

Affirming the rule presently mandated in Wisconsin by its Court of Appeals will allow many institutionalized spouses to qualify for Medicaid more readily than the resource and income limits otherwise would permit. Reviewers tasked to determine whether an obligation to reallocate marital resources exists will be required to disregard the existence of income that will be available to a community spouse while an institutional spouse remains on Medicaid. Private-pay residents who could still shoulder the costs of their care will expedite their eligibility for Medicaid by having assets far above the standard CSRA, and not needed to ensure a particular post-eligibility income stream for their spouses, sheltered.

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imposes a first come, first served rule. *See* Tenn. Comp. R. & Regs. ch. 1200-13-1-08(4) (2000).

Respondent has tended to characterize this case as a parochial matter involving $14,500 in additional resources. But the financial realities for the government programs are no different for Wisconsin and the federal government now than they were in any of the prior cases. When Thomas Cleary brought his lawsuit against New Jersey, he sought to exclude an additional $167,040 in assets that he estimated were required to produce an additional $696.26 in monthly income. *Cleary*, 959 F. Supp. at 227-228. In his complaint, Mr. Cleary also estimated that if the resource first rule were mandated as he was requesting, approximately ten thousand residents of New Jersey's nursing homes would become immediately eligible for Medicaid, changing both the balance of payments to long term care providers and the financial burdens on both that state and the federal government. *Id.* at 225. Similarly, Wisconsin estimates here that if it is required to disregard income that could be used to supplement a community spouse's MMMNA merely because pre-eligibility, before the MMMNA issue ripens, such income is deemed available only to the institutional spouse, Wisconsin can expect to pay significantly more in program costs—an additional $2.4 million annually for each 100 newly-eligible Medicaid residents whose health care would otherwise have been privately financed. *See* Petitioner's Petition for Writ of Certiorari at 20.

Individual responsibility for the costs of health care prior to Medicaid eligibility is an important value underlying the Medicaid program and a cornerstone of long term care financing. Respondent's assertion that the spousal impoverishment provisions mandate the use of a "resource first" approach is inconsistent with the language of the Medicaid provisions at issue and reflects a misapprehension of how the provisions work to protect community spouses while preserving poverty-based eligibility. By ignoring income that will in fact be made available post-eligibility to meet the

needs of the community spouse, merely on the basis that an eligibility review necessarily occurs before eligibility attaches and a mistaken assumption that the statute entitles a spouse to a minimum income stream pre-eligibility, the Wisconsin Court of Appeals decision undermines individual financial responsibility for health care. Insofar as respondent and others similarly situated are permitted to upset a financing balance Congress crafted with states by permitting income that states make available to be ignored, in order to hasten eligibility by protecting excess resources, this issue also carries extremely important practical consequences for providers of long term care. Nothing in the spousal impoverishment provisions or their legislative history suggests that Congress intended to destabilize the industry through elimination of a substantial portion of a significant source of long term care revenue. In truth, Wisconsin's method of ensuring community spousal income protection is consistent with a federal statutory scheme that carefully balances the program's limited resources against individuals' obligations and responsibilities.

CONCLUSION

For the foregoing reasons, this Court should REVERSE the decision of the Wisconsin Court of Appeals.

Respectfully submitted,

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